

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

16947

1. PLACE OF DEATH o. COUNTY <u>Carrall</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carrall</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millers</u>		c. LENGTH OF STAY IN 1b <u>17 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>(none)</u> Last <u>Asper</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>22</u> Year <u>1966</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 26 - 1884</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Carrall Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick BOERNER</u>		14. MOTHER'S MAIDEN NAME <u>MARY C. E. STUMP</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-28-8864</u>	
17. INFORMANT <u>Jacob Asper</u>		Address <u>Millers Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular</u> DUE TO (c) <u>Hypertension Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>10 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 1950, to <u>Dec 22</u> , 1966, that I last saw the deceased alive on <u>Aug</u> , 1966, and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Hoard</u>		ADDRESS (Street, city or town, state) <u>25 N Main St</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Hoard M.D.</u>		DATE SIGNED <u>12/22/66</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/24/66</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jipton - E Line Fun. Home, Hampstead, Md.</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u>DEC 27 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

1900

PLACE OF DEATH		MARRIAGE	
1. CITY OR TOWN OF DEATH		2. DATE OF MARRIAGE	
3. NAME OF DECEASED		4. NAME OF SPOUSE	
5. SEX		6. AGE	
7. OCCUPATION		8. CAUSE OF DEATH	
9. PLACE OF BIRTH		10. DATE OF BIRTH	
11. PLACE OF DEATH		12. DATE OF DEATH	
13. PLACE OF INTERMENT		14. DATE OF INTERMENT	
15. PLACE OF BURIAL		16. DATE OF BURIAL	
17. PLACE OF CREMATION		18. DATE OF CREMATION	
19. PLACE OF EXHUMATION		20. DATE OF EXHUMATION	
21. PLACE OF REINTERMENT		22. DATE OF REINTERMENT	
23. PLACE OF REINTERMENT		24. DATE OF REINTERMENT	
25. PLACE OF REINTERMENT		26. DATE OF REINTERMENT	
27. PLACE OF REINTERMENT		28. DATE OF REINTERMENT	
29. PLACE OF REINTERMENT		30. DATE OF REINTERMENT	
31. PLACE OF REINTERMENT		32. DATE OF REINTERMENT	
33. PLACE OF REINTERMENT		34. DATE OF REINTERMENT	
35. PLACE OF REINTERMENT		36. DATE OF REINTERMENT	
37. PLACE OF REINTERMENT		38. DATE OF REINTERMENT	
39. PLACE OF REINTERMENT		40. DATE OF REINTERMENT	
41. PLACE OF REINTERMENT		42. DATE OF REINTERMENT	
43. PLACE OF REINTERMENT		44. DATE OF REINTERMENT	
45. PLACE OF REINTERMENT		46. DATE OF REINTERMENT	
47. PLACE OF REINTERMENT		48. DATE OF REINTERMENT	
49. PLACE OF REINTERMENT		50. DATE OF REINTERMENT	
51. PLACE OF REINTERMENT		52. DATE OF REINTERMENT	
53. PLACE OF REINTERMENT		54. DATE OF REINTERMENT	
55. PLACE OF REINTERMENT		56. DATE OF REINTERMENT	
57. PLACE OF REINTERMENT		58. DATE OF REINTERMENT	
59. PLACE OF REINTERMENT		60. DATE OF REINTERMENT	
61. PLACE OF REINTERMENT		62. DATE OF REINTERMENT	
63. PLACE OF REINTERMENT		64. DATE OF REINTERMENT	
65. PLACE OF REINTERMENT		66. DATE OF REINTERMENT	
67. PLACE OF REINTERMENT		68. DATE OF REINTERMENT	
69. PLACE OF REINTERMENT		70. DATE OF REINTERMENT	
71. PLACE OF REINTERMENT		72. DATE OF REINTERMENT	
73. PLACE OF REINTERMENT		74. DATE OF REINTERMENT	
75. PLACE OF REINTERMENT		76. DATE OF REINTERMENT	
77. PLACE OF REINTERMENT		78. DATE OF REINTERMENT	
79. PLACE OF REINTERMENT		80. DATE OF REINTERMENT	
81. PLACE OF REINTERMENT		82. DATE OF REINTERMENT	
83. PLACE OF REINTERMENT		84. DATE OF REINTERMENT	
85. PLACE OF REINTERMENT		86. DATE OF REINTERMENT	
87. PLACE OF REINTERMENT		88. DATE OF REINTERMENT	
89. PLACE OF REINTERMENT		90. DATE OF REINTERMENT	
91. PLACE OF REINTERMENT		92. DATE OF REINTERMENT	
93. PLACE OF REINTERMENT		94. DATE OF REINTERMENT	
95. PLACE OF REINTERMENT		96. DATE OF REINTERMENT	
97. PLACE OF REINTERMENT		98. DATE OF REINTERMENT	
99. PLACE OF REINTERMENT		100. DATE OF REINTERMENT	

16950

CERTIFICATE OF DEATH

Reg. Dist. No.

16948

1. PLACE OF DEATH a. COUNTY <u>CARROLL CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER RTA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>	
c. LENGTH OF STAY IN 1b <u>9 MO.</u>		d. STREET ADDRESS <u>NEAR MAYBERRY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NEAR MAYBERRY</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NOAH HARVEY BABYLON</u>		4. DATE OF DEATH Month Day Year <u>DEC. 10 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 14, 1982</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMPLOYED</u>	
11. BIRTHPLACE (State or foreign country) <u>CARROLL CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB BABYLON</u>		14. MOTHER'S MAIDEN NAME <u>ANN RINEHART</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>213-36-8635</u>	
17. INFORMANT <u>ROY G. JACKSON</u>		Address <u>SAME ADDRESS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V.D.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>422.1</u> DUE TO (c) <u>years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>Oct.</u> , 19 <u>56</u> , to <u>12/10/66</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>12/9/66</u> , 19 <u>—</u> , and that death occurred at <u>11:45 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>New Windsor, Ind</u> <u>12/10/66</u> ACTUAL SIGNATURE <u>M.E. Robertson</u> M.D. <u>—</u> PHYSICIAN'S NAME (Type) <u>M.E. ROBERTSON MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/13/66</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BAUST CHURCH CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL, WESTMINSTER, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr., Westminster, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 13 1966</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

15250

CARROLL

MCKINLEY

CARROLL

RURAL HYGIENIST

RURAL HYGIENIST

NEAR MYSTERY

NEAR MYSTERY

DEC 10 1944

NOAH HARVEY BABYLOW

FEB 14 1921

WHITE

SELF-EMPLOYED CARROLL CO. MD

FARMER

RAY RINEHART

JACOB BABYLOW

SAINT
ANNE'S

25-2525 RY & JACKSON

Outstanding

12/10/44

out

12/1/44

M. E. Robertson

M. E. Robertson, MD

New Windsor, Md 12/10/44

RURAL HYGIENIST GENERAL RURAL HYGIENIST, MD

P. J. Murphy, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16951

CERTIFICATE OF DEATH

16949

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westminster				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westminster			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Caples Nursing Home				d. STREET ADDRESS 06.1			
3. NAME OF DECEASED (Type or print) First FANNIE Middle MAE Last BAILEY				4. DATE OF DEATH Month 12 Day 12 Year 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/5/89	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.		11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hwf				10b. KIND OF BUSINESS OR INDUSTRY North Carolina			
13. FATHER'S NAME Ruben Bailey Peterson				14. MOTHER'S MAIDEN NAME Polly ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 212-14-0673B		17. INFORMANT Mr. Hubert Bailey Address Westminster, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis Acute DUE TO (b) Atherosclerotic Cardio Vascular DUE TO (c) Disease & Hypertension underlying cause last. Chronic Arthritis				INTERVAL BETWEEN ONSET AND DEATH Hours Several years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-29 , 19 63 to 12-12 , 19 66 , that (I) (we) last saw the deceased alive on 12-11 , 19 66 , and that death occurred at 2:45 M., from the causes and on the date stated above.							
22a. SIGNATURE William Speicher				22b. DATE SIGNED 12-13-66		22c. PHYSICIAN'S NAME (Type) 135 E. Main Wks. Inc. Inc. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/14/66		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION (City, town or county) (State) Balto. Co. Md.	
24. FUNERAL DIRECTOR Tipton-Eline Fun. Home, Hampstead, Md.				25a. REC'D BY REGISTRAR DEC 15 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

100318

100318

100318

100318

100318

100318

100318

100318

100318

100318

100318

100318

100318

100318

100318

100318

100318

100318

100318

100318

100318

100318

100318

100318

100318

100318

100318

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16952

CERTIFICATE OF DEATH

16950

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN lb <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MATTHEWSTOWN</u> 20.2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL COUNTY HOSPITAL</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>ETHEL</u> Middle <u>R</u> Last <u>BARWICK</u>				4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 10 1883</u>		9. AGE (In years last birthday) yrs. <u>83</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COWNHINE & NURSING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>TALBOT</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOSEPH R. STEWART</u>				14. MOTHER'S MAIDEN NAME <u>LAURA WHITE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-32-1002</u>		17. INFORMANT <u>Mrs DOROTHY R. BRIFFITH</u>		Address <u>HAMPSTEAD MARYLAND</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY ADENOMATOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CONGESTIVE HEART FAILURE</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/10</u> , 19 <u>66</u> , to <u>12/17</u> , 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>12/17</u> , 19 <u>66</u> , and that death occurred at <u>4:35</u> M, from causes on and on the date stated above.							
22a. SIGNATURE <u>Vincent J. Brown Jr</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/17/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Westminster, Md</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		23b. DATE THEREOF <u>12-20-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL</u>		23d. LOCATION (City or Town) (County) (State) <u>EASTON TALBOT MD</u>	
24. FUNERAL DIRECTOR <u>Robert Clark</u>				25a. REC'D BY REGISTRAR <u>Easton Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10221

10222

STATE OF TEXAS

COUNTY OF _____	
CITY OF _____	
STATE OF TEXAS	
I, _____, of the County of _____, State of Texas, do hereby certify that _____ is a resident of the County of _____, State of Texas.	
Witness my hand and seal this _____ day of _____, 19____.	
_____ Notary Public for Texas	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16953

CERTIFICATE OF DEATH

16951

1. PLACE OF DEATH a. COUNTY <u>CARROLL CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, WESTMINSTER</u> 06.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>R.F.D. #5</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>CASPER</u> Last <u>BAUERLIEN</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>21</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 25, 1885</u> 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE CO., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. GEORGE BAUERLIEN</u>		14. MOTHER'S MAIDEN NAME <u>LENA YEAGER</u>	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-44-0134</u>	
17. INFORMANT <u>MRS. J. FRANCES GESELL</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary emphysema</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 17</u> , 19 <u>66</u> , to <u>Dec 21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 21</u> , 19 <u>66</u> , and that death occurred at <u>3:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u>		22b. DATE SIGNED <u>12/21/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>8 Anson St. Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/24/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Westminster, Md.</u>	
24. FUNERAL DIRECTOR <u>J. S. Meyer, Jr., Westminster, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 21 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10031

STATE OF TEXAS

10031

Blank document with faint horizontal lines and two punch holes on the right side.

16954

CERTIFICATE OF DEATH

16952

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Pa</i> b. COUNTY <i>York</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hartshorn</i>	c. LENGTH OF STAY IN 1b <i>1 day</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Rock Rural</i> <i>75.3</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Carroll Co. Hospital</i>		d. STREET ADDRESS <i>P.O. #1</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>WILLARD</i> Middle <i>C</i> Last <i>BEACH</i>		4. DATE OF DEATH Month <i>12</i> Day <i>28</i> Year <i>1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 6 1893</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MANUFACTURER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HARNESS</i>	9. AGE (In years lost birthday) <i>73</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <i>NEW JERSEY</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>WARREN BEACH</i>		14. MOTHER'S MAIDEN NAME <i>IRENE HILL</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>145-01-5318A</i>	
17. INFORMANT <i>Wm. Holland C. Beach</i>		Address <i>Glen Rock, Pa. #1</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i> DUE TO (b) <i>ACUTE MYOCARDIAL INFARCTION</i> DUE TO (c) <i>ARTERIOSCLEROTIC HEART DISEASE</i>			INTERVAL BETWEEN ONSET AND DEATH <i>45 MIN.</i> <i>40 HRS.</i> <i>YEARS.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>12/28</i> , 19 <i>66</i> , to <i>12/28</i> , 19 <i>66</i> , and that death occurred at <i>5:45</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Vincent J. Krosch Jr.</i> M.D.		22b. DATE SIGNED <i>12/28/66</i>	22c. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <i>Vincent J. Krosch Jr.</i>		22e. ADDRESS <i>Glen Rock, Pa</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried at Glen Rock</i>	23b. DATE THEREOF <i>12/31/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>BASKING RIDGE</i>	23d. LOCATION (City or Town) (County) (State) <i>BASKING RIDGE NJ</i>
24. FUNERAL DIRECTOR <i>Joe C. Copley</i>		25a. REC'D BY REGISTRAR <i>DEC 30 1966</i>	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10035

(REPHOTO OF DEATH)

10035

ARTERIOSCLECTIC HEMET DISC
ACUTE MYOCARDIAL INFARCTION

42 min
10 hrs
1962

1978 12/28 62
1978 12/28 62
1978 12/28 62

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16955					16953				
1. PLACE OF DEATH a. COUNTY CARROLL COUNTY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER			c. LENGTH OF STAY IN 1b 2 1/2 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give Street address) 56 1/2 JOHN STREET					d. STREET ADDRESS 56 1/2 JOHN STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LEANNA CATHERIN BROWN			First Middle Last		4. DATE OF DEATH DEC 2		Month Day Year 19 66		
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 6. 1903		9. AGE (In years last birthday) 63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10b. KIND OF BUSINESS OR INDUSTRY CLOTHING		11. BIRTHPLACE (County & State, or foreign country) CARROLL COUNTY			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JESSIE LEVI - BROWN				14. MOTHER'S MAIDEN NAME ROSE ROWE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 213-05-3867		17. INFORMANT MRS. ALICE E. STEM Address 98 N. RALPH ST. WESTMINSTER, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage DUE TO (b) Hypertension & Arteriosclerosis DUE TO (c) Had Stroke approx 8-1963 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH 1 day Several yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from April 8, 1963, to Dec 2, 1966, that (I) (we) last saw the deceased alive on Dec 1, 1966, and that death occurred at 11:00 AM, from the causes and on the date stated above.									
22a. SIGNATURE William Speicher				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) DR. W. GLENN SPEICHER				22b. DATE SIGNED 12-2-66					
22d. ADDRESS 135 E. MAIN ST. WESTMINSTER, MD									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC 4 1966		23c. NAME OF CEMETERY OR CREMATORY WESTMINSTER CEM.		23d. LOCATION (City, town or county) (State) WESTMINSTER MD.			
24. FUNERAL DIRECTOR James B. Saffelt				ADDRESS WESTMINSTER, MD		25a. REC'D BY REGISTRAR DEC 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

1893

1893



16956

CERTIFICATE OF DEATH

16954

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN lb <u>3 WEEKS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>MAPLE AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>THEODORE FRANKLIN BROWN</u>		4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 16, 1885</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAWYER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMPLOYED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>NELSON A. BROWN</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN J. MAUS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>217-28-7387</u>	
17. INFORMANT <u>MRS. GEO. L. GASSMAN</u>		Address <u>MAPLE AVE. WESTMINSTER, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>334X</u> IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR INSUFFICIENCY</u> DUE TO (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u> <u>"</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/12</u> , 19 <u>66</u> , to <u>12/23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/23</u> , 19 <u>66</u> , and that death occurred at <u>6:38</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Vincent J. Fiocco, Jr.</u> M.D.		22b. DATE SIGNED <u>12/23/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>VINCENT J. FIOCCO, JR.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12/27/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARKS CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>SILVER RUN, CARROLL CO. MD.</u>
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr., Westminster, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 27 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10034

10034

10034

GENERAL ATTORNEY
GENERAL ATTORNEY

GENERAL ATTORNEY

1914
1914
1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16957 **CERTIFICATE OF DEATH** **16955**

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Md. d. STREET ADDRESS Main Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charlotte Ann Buckingham		4. DATE OF DEATH 12 30 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-7-83
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dallas Shipley		14. MOTHER'S MAIDEN NAME Catherine Fowler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-03-1952	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prob. Acute Coronary Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Atherosclerotic Cardiovascular Disease (c) 4221		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-20 , 19 66 , to 12-30 , 19 66 , that (I) (we) last saw the deceased alive on 12-29 , 19 66 , and that death occurred at 5 A.M. from the causes and on the date stated above.			
22a. SIGNATURE H. E. Connor Jr MD		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) H. E. CONNOR		22d. ADDRESS Springfield State Hosp., Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-2-67	
23c. NAME OF CEMETERY OR CREMATORY Taylorville Cemetery		23d. LOCATION (City, town or county) (State) Carroll Co. Md.	
24. FUNERAL DIRECTOR Harry W. Haight Sykesville, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE JAN 4 1967	

Dietary

9 9 9

1

— — —

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
169558 CERTIFICATE OF DEATH 16956											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Longview Nursing Home Inc.</u>						d. STREET ADDRESS <u>104 Park Avenue</u>					
3. NAME OF DECEASED (Type or print) First <u>MARK</u> Middle <u>MANDILLA</u> Last <u>BURGOON</u>						4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1966</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 4, 1872</u>		9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>CONRAD NAGLE</u>						14. MOTHER'S MAIDEN NAME <u>SARAH BRILHART</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u> </u>		Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>47</u> , to <u>Dec 24</u> , 19 <u>66</u> , that (II) (we) last saw the deceased alive on <u>Dec 23</u> , 19 <u>66</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.				22a. SIGNATURE <u>W H Foard</u>			
22b. DATE SIGNED <u>12/25/66</u>				22c. PHYSICIAN'S NAME (Type) <u>W. H FOARD M.D.</u>				22d. ADDRESS <u>Manchester, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Manchester Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Manchester Md. Carroll Co.</u>			
24. FUNERAL DIRECTOR <u>Wayne V. Knowlton</u>				24a. ADDRESS <u>269 Frederick St. Hagerstown</u>		24b. REC'D BY REGISTRAR <u>DEC 28 1966</u>		24c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10026

10026



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16959

CERTIFICATE OF DEATH

16957

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3Yrs. 5mo. 6days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 508 Woodside Ave	
3. NAME OF DECEASED (Type or print) First Middle Last Minnie Elizabeth Cessna		4. DATE OF DEATH Month Day Year 12 25 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-21-88
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Landlady		10b. KIND OF BUSINESS OR INDUSTRY Rooming house	
11. BIRTHPLACE (County & State, or foreign country) Somerset Co. Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry J. Knieriem		14. MOTHER'S MAIDEN NAME Annie Sipple	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-32-3362	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocard Infarction DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-19-63 , 19 65 , to 12-25- , 19 66 that (I) (we) last saw the deceased alive on 10-15 , 19 66 , and that death occurred at 10 PM , from causes and on the date stated above.			
22a. SIGNATURE H. E. HATNER		22b. DATE SIGNED 12-25-66	
22c. PHYSICIAN'S NAME (Type) H. E. HATNER		22d. ADDRESS Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/29/66	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE: 20 1966	
25b. REGISTRAR'S SIGNATURE O. Charles Judge			

10037

RECEIVED OF BIRTH

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

10037

16960

CERTIFICATE OF DEATH

16958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 30.4 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VELMA Middle (nmn) Last CORNETT		4. DATE OF DEATH Month 12 Day 24 Year 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-5-23
9. AGE (In years last birthday) yrs. 42		10. IF UNDER 1 YEAR Months 12 Days 24 Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dennis Lomax		14. MOTHER'S MAIDEN NAME Bessie Wiggins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 5811 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 026X(c) (b) Nutritional Cirrhosis of Liver DUE TO (c) Chronic brain syndrome associated with central nervous system syphilis, meningovascular, with psychotic reaction. Alcoholism (addiction). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with central nervous system syphilis, meningovascular, with psychotic reaction. Alcoholism (addiction). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-9-65 , 19__, to 12/24/66 , 19__, that (I) (we) last saw the deceased alive on 12/24/66 , 19__, and that death occurred at 7:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Ronald N. Kornblum M.D.		22b. DATE SIGNED 12/26/66	
22c. PHYSICIAN'S NAME (Type) Ronald N. Kornblum		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-29-66	
23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Geo. L. Nelson ADDRESS 1348 N. Calhoun St.		25a. REC'D BY REGISTRAR DEC 27 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

1035

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16961

CERTIFICATE OF DEATH

16959

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2yr. 2mos. 1dy.	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					d. STREET ADDRESS 8407 Cedar Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EDWARD		Middle ALEXANDER		Last COTTRELL		4. DATE OF DEATH Month December 13 19 66		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-1880		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Isaac Benjamin Cottrell				14. MOTHER'S MAIDEN NAME Mary Alexander Ball				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 220-54-6700		17. INFORMANT Address Records, Springfield State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Carcinoma of prostate gland DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with alcoholism with behavioral reaction.								INTERVAL BETWEEN ONSET AND DEATH Days Months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10-12-64 , 19 64 , to 12-13-66 , 19 66 , that (I) (we) last saw the deceased alive on 12-13-66 , 19 66 , and that death occurred at 3:15 A.M. , from causes and on the date stated above.								
22a. SIGNATURE <i>Octavio A. Ruiz</i>						22b. DATE SIGNED 12-13-66		
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.				22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/14/66		23c. NAME OF CEMETERY OR CREMATORY MT. CARMEL CEM.		23d. LOCATION (City or Town) (County) (State) MOORESTOWN. BURL. N.J.		
24. FUNERAL DIRECTOR <i>Ruthwood Haight</i>				ADDRESS <i>Sykesville, Md.</i>		25a. REC'D BY REGISTRAR DATE DEC 19 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16962

16960

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 3mos. 6dys. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 1301 Oldtown Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HARVEY CLEVELAND CROFT				4. DATE OF DEATH Month Day Year DECEMBER 15 19 66			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-25-1884	
9. AGE (In years last birthday) 82 yrs.				IF UNDER 1 YEAR Months Days 82		IF UNDER 24 HRS. Hours Min. 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Alexander Croft			
14. MOTHER'S MAIDEN NAME Ellen (last name unk.)				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk.			
16. SOCIAL SECURITY NO. 213-18-2706				17. INFORMANT Records, Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Nephrosclerosis DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture, neck of left femur							INTERVAL BETWEEN ONSET AND DEATH Days Months Years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell to floor, could not get up by himself.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9 11-2- 19 66				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ward G-1, dining area, Men's Group				20f. (City or town) (County) (State) Springfield State Hospital Sykesville, Carroll, Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>W. Glenn Speicher</i>				22. DATE SIGNED 12-15-66			
EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.				135 E. Main, Westminster, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 18 '66		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION (City, town or county) (State) Garrett County, Md.	
24. FUNERAL DIRECTOR Joseph R. Durst, Sr., Frostburg, Md.				25a. REC'D BY REGISTRAR DEC 21 1966			
				25b. REGISTRAR'S SIGNATURE <i>James Judge</i>			

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

10308

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16963 CERTIFICATE OF DEATH 16961											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u> 06.1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Golden Age Quiet Home</u>						d. STREET ADDRESS <u>Buckhorn Rd -</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Naomi</u> Middle <u>Naomi</u> Last <u>Critchley</u>						4. DATE OF DEATH Month <u>Dec.</u> Day <u>4</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>? ? - 1882</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>84</u> Days <u>84</u> Hours <u>84</u> Min. <u>84</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sewing</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Nathan Eminov</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Mrs. Myra Talbott -</u>				Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Genl Cardio Vascular</u> DUE TO (c) <u>P.</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>6/5</u> , 19 <u>65</u> to <u>Dec 4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 3</u> , 19 <u>66</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>H. J. Martin</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Dec 4 - 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. J. MARTIN</u>						22d. ADDRESS <u>Westminster</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>12-6-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>						ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10001

10001



16964

CERTIFICATE OF DEATH

16962

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Md.		c. LENGTH OF STAY IN lb. 4 yrs. 28days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 7528 Holabird Ave.	
3. NAME OF DECEASED (Type or print) Carolina First (Alvernia) Middle Last		4. DATE OF DEATH Month December Day 18 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-22-79
9. AGE (In years last birthday) yrs. 87		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isac Bell		14. MOTHER'S MAIDEN NAME Almeda Stemple	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) C.V.A. DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-20- , 19 62 , to 12-18 , 19 66 , that (I) (we) last saw the deceased alive on 12-18 , 19 66 , and that death occurred at 2:00 M, from causes and on the date stated above.			
22a. SIGNATURE <i>Ilse Kamm</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Ilse Kamm M.D.		22d. ADDRESS Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/21/66	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Robert C. Altenburg - 6009 Harford Rd.		25a. REC'D BY REGISTRAR DATE DEC 20 1966	
Funeral Home, Inc.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

1890

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
16965													
16963													
1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>Maryland</i> c. COUNTY <i>Carroll</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Westminster</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Long View Nursing Home Inc.</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Alice</i> Middle <i>M</i> Last <i>Deal</i>						4. DATE OF DEATH Month <i>December</i> Day <i>11</i> Year <i>1966</i>							
5. SEX <i>F</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-16-1883</i>		9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Newfoundland</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Ambrose Emberley</i>						14. MOTHER'S MAIDEN NAME <i>Mary Ann Williams</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>215-03-4713</i>		17. INFORMANT <i>Institution Records, Long View Nursing Home</i> Address <i>Manchester</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> <i>4221</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (c) <i>Intestinal obstr - Colostomy</i>												INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Intestinal obstr - Colostomy</i>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>Oct</i> , 19 <i>62</i> to <i>Dec</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12/8</i> , 19 <i>66</i> , and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.													
22a. SIGNATURE <i>D. A. Knight</i>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12/11/66</i>					
22c. PHYSICIAN'S NAME (Type) <i>D. A. Knight M.D.</i>						22d. ADDRESS <i>Greenmount, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>12-15-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenmount Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>					
24. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc Baltimore, Md.</i>						25a. REC'D BY REGISTRAR <i>DEC 14 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

1888

Canal

Marland

Boat - Westchester

Boat - Westchester

Longview Nursing Home Inc

Alice

M

Deal

December 11 88

2-16-1883 83

White

F

Horsework

Amber Embury

215-23-1113 Jackson Road, Longview Nursing Home

No

Substantive work - Longview

1/2

1/2

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

<div> <div>4</div> <div>1</div> <div>M</div> </div> <div> <div>FOR STATE HEALTH DEPT.</div> </div>											
<div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div>											
1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE						c. LENGTH OF STAY IN 1b HOURS					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 00 RURAL MCKINSTRYS MILLS						d. STREET ADDRESS RURAL					
3. NAME OF DECEASED (Type or print) First Middle Last ISOM EUGENE DEAN						4. DATE OF DEATH Month Day Year DEC 23, 1966					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 18-1947		9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT				10b. KIND OF BUSINESS OR INDUSTRY COLLEGE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY US			
13. FATHER'S NAME ISOM L. DEAN						14. MOTHER'S MAIDEN NAME DAISY GREGORY					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 218-44-9841		17. INFORMANT Address MRS. LENIS D. BARNEY, BALTIMORE MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X Gunshot (Right Chest) wound Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Self Inflicted DUE TO (b) Chest DUE TO (c) Sudden PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Shot self in chest (22 caliber)											
20c. TIME OF INJURY Month, Day, Year 2:00 a.m. 12/23/66				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rural Union Bridge and Carroll		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE W. Glenn Speicher M.D.						22. DATE SIGNED 12/23/66					
EXAMINER'S NAME (Type) W. GLENN SPEICHER						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						23b. DATE THEREOF 12-27-66		23c. NAME OF CEMETERY OR CREMATORY WINTERS CEM. CARROLL COUNTY MD		23d. LOCATION (City, town or county) (State) NEW WINDSOR MD	
24. FUNERAL DIRECTOR D.W. Hartzfeld						25a. REC'D BY REGISTRAR DEC 27 1966		25b. REGISTRAR'S SIGNATURE Charles J...			

10324

10324

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16967 CERTIFICATE OF DEATH 16965

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md.</u> c. LENGTH OF STAY IN 1b <u>7 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home 128 W. Main St</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Greenmount, Md. 16.1</u> d. STREET ADDRESS <u>none</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Arthur</u> Last <u>De Hoff</u>		4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1966</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 24, 1877</u>		9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Agent</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Rural Hempstead, Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Jacob De Hoff</u>								14. MOTHER'S MAIDEN NAME <u>Mary C. Royer</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>705-10-7351</u>				17. INFORMANT <u>Dore Undersmith (daughter)</u> Address <u>Reston, Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Arteriosclerotic Cardiovascular Disease</u> DUE TO (b) <u>Vascular Disease</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>5/5</u> , 19 <u>66</u> , to <u>12/7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 2</u> , 19 <u>66</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.																	
22a. SIGNATURE <u>W H Foard</u>														22b. DATE SIGNED <u>12/7/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. H Foard M.D.</u>				22d. ADDRESS <u>Manchester, Md.</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12/10/66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Greenmount, Md.</u>					
24. FUNERAL DIRECTOR ADDRESS <u>Tipton- Eline Funeral Home Hampstead, Md.</u>								25a. REC'D BY REGISTRAR <u>DEC 13 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

[illegible]

2001

Handwritten: *Handwritten: 1844*

۴۹ ملک بن احمد

Richard Gurney

front the wall

en

28 1831, 1832

Received of the
General Hospital, 1904

Wm. C. Brown

(with friend) returned to Virology 12/27-01 - 205

9052

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16968

CERTIFICATE OF DEATH

16966

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>30.4</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> d. STREET ADDRESS <u>5105 Arbutus Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>IDA DENNIS</u> First Middle Last 4. DATE OF DEATH <u>December 25, 1966</u> Month Day Year				5. SEX <u>F.</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12-25-98</u> 9. AGE (in years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Sol Radin</u> 14. MOTHER'S MAIDEN NAME <u>Celia ?</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-56-6430</u>		17. INFORMANT <u>Records of Springfield State Hospital</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory collapse</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic C.V.D.</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>Years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome of unknown or uncertain cause w/psychotic reac.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>11-30-66</u> , 19 <u>66</u> , to <u>12/25/</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/25/</u> , 19 <u>66</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Adnan Sonmez</u> 22b. DATE SIGNED <u>12/25/1966</u> 22c. PHYSICIAN'S NAME (Type) <u>ADNAN SONMEZ</u> 22d. ADDRESS <u>Springfield State Hospital Sykesville, MD</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oheb Shalom</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reisterstown</u>				25a. REC'D BY REGISTRAR <u>DEC 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10000

10000

10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. These pages must be removed from the certificate. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16969
CERTIFICATE OF DEATH
16967

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>9 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pullen Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> d. STREET ADDRESS <u>Dogwood Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry F. Duvall</u>		4. DATE OF DEATH <u>Dec 4 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 4, 1884</u>
9. AGE (In years last birthday) <u>82 yrs.</u>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Repairs</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>George F. Duvall Sr. 3405 Mayfield Ave 21207</u>	
17. INFORMANT <u>George F. Duvall Sr. 3405 Mayfield Ave 21207</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary Edema</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cardiac failure</u> (c) <u>Arteriosclerotic Cardiovascular</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>48 hours</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I (a) <u>Wernicke Coma; Nephrosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sep 26, 1966</u> to <u>Dec 4, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec 4, 1966</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Sani Okutman</u> M.D.		22b. DATE SIGNED <u>Dec 4, 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Sani Okutman</u>		22d. ADDRESS <u>Sykesville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL* (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/7/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Amberse Inc. 1328 Sulphur Sp. Rd.</u>		25a. REC'D BY REGISTRAR <u>DEC 6 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10000

10001

CENTRICAL OF DEATH

RECEIVED BY THE NATIONAL BUREAU OF INVESTIGATION

Handwritten notes and stamps, including "RECEIVED" and "FBI" markings, are visible in the upper section of the document.

Handwritten notes and stamps, including "RECEIVED" and "FBI" markings, are visible in the lower section of the document.

DEC 1966

Handwritten signature or initials.

16970

CERTIFICATE OF DEATH

16968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u> COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BARK HILL</u>				c. LENGTH OF STAY IN lb <u>YEARS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION BRIDGE RURAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GRACE RUTH ECKARD</u>				4. DATE OF DEATH <u>DEC 2 1966</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-30-1898</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>				13. FATHER'S NAME <u>SAMUEL I MACKLEY</u>			
14. MOTHER'S MAIDEN NAME <u>LAURA MOLESWORTH</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>				17. INFORMANT <u>J. H. ECKARD, UNION BRIDGE MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic CVD</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1</u> , 19 <u>46</u> , to <u>12/2/66</u> , 19 <u> </u> , that (I) <u>(we)</u> last saw the deceased alive on <u>12/2/66</u> 19 <u> </u> , and that death occurred at <u>3:45 PM</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>M. E. Robertson</u>				22b. DATE SIGNED <u>12/2/66</u>		22c. PHYSICIAN'S NAME (Type) <u>M. E. ROBERTSON</u>	
22d. ADDRESS <u>New Windsor, Md.</u>				22e. REC'D BY REGISTRAR <u>DEC 7 1966</u>			
22f. REGISTRAR'S SIGNATURE <u>John C. Jones</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
23b. DATE THEREOF <u>12-5-66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM</u>			
23d. LOCATION (City or Town) (County) (State) <u>CARROLL COUNTY MD</u>				23e. FUNERAL DIRECTOR <u>O. D. Harkler & Sons</u>			
23f. ADDRESS <u>UNION BRIDGE MD</u>				23g. DATE <u>DEC 7 1966</u>			

22621

11503

(continued)

Antennariolepis C. B.

12/12/12

12/2/84

Mr. E. Robinson

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RR 2

VR A15ME
3500 4-64

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, state and date of admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER, MD. 0611</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>20 CHURCH STREET</u>		d. STREET ADDRESS <u>#20 CHURCH STREET</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY CLINTON FLATER</u>		4. DATE OF DEATH Month Day Year <u>DEC. 5TH 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 26, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>CARROLL COUNTY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>PHILIP FLATER</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH WALKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-09-3398</u>	
17. INFORMANT <u>NORMAN FLATER</u> Address <u>SANDY MOUNT ROAD</u>		17. INFORMANT <u>FLIKS BURG, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Congestive Heart Failure</u> (b) <u>Arteriosclerosis (renal)</u> DUE TO <u>General</u> (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Glenn Speicher</u>		22. DATE SIGNED <u>12-7-66</u>	
EXAMINER'S NAME (Type) <u>W. GLENN SPEICHER</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>DEC. 9/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SANDY MOUNT CEM.</u>		23d. LOCATION (City, town or county) <u>SANDY MOUNT, MD.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Saffell Jr.</u>		25a. REC'D BY REGISTRAR <u>DEC 9 1966</u>	
ADDRESS <u>WESTMINSTER, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

PLEASANT GROVE

1833

1833

1833

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00

0

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16972

CERTIFICATE OF DEATH

16970

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Union Bridge		c. LENGTH OF STAY IN 1b 3 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Route 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Florence May Foreman		4. DATE OF DEATH December 2, 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1889
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Moser	
14. MOTHER'S MAIDEN NAME Elizabeth Wantz		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 220-01-6956		17. INFORMANT Mrs. Harry Pittinger, R #5, Westminster, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Artery Thrombosis DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO 10 yrs. (c) Generalized Arteriosclerosis 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH 2 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diverticulosis of the Sigmoid Colon		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 9/9 , 19 59 to 12/2 , 19 66 that (I) was saw the deceased alive on 12/1 , 19 66 , and that death occurred 12/2 P. from causes and on the date stated above.	
22a. SIGNATURE R. S. McVaugh		22b. DATE SIGNED 12/3/66	
22c. PHYSICIAN'S NAME (Type) R. S. McVaugh		22d. ADDRESS Taneytown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 5, 1966	
23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		23d. LOCATION (City or Town) (County) (State) Taneytown, Carroll, Maryland	
24. FUNERAL DIRECTOR John H. Skiles		25a. REC'D BY REGISTRAR O.O. Fuss & Son, Taneytown, Maryland	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE DEC 5 1966	

10030

RECEIVED

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

10030

16973

CERTIFICATE OF DEATH

18053

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. LENGTH OF STAY IN 1b <u>1 mo. 6 d.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospi.</u>		d. STREET ADDRESS <u>MT. AIRY</u>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>ETTA</u> Last <u>Fossett</u>		4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-1-22</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Hutchinson, Joseph</u>		14. MOTHER'S MAIDEN NAME <u>Ridgley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>205-01-6642B</u>	
17. INFORMANT <u>Springfield Hospital/records</u>		Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>522X</u> IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> DUE TO (b) <u>HYPOSTATIC PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>DAYS</u> <u>DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CBS, senile brain disease, psychotic reaction</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-25-</u> , 19 <u>66</u> , to <u>12-31</u> , 19 <u>66</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>12-31-</u> , 19 <u>66</u> , and that death occurred at <u>2:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Naci N. Buyukunsal</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>12-31-66</u>
22c. PHYSICIAN'S NAME (Type) <u>NACI N. BUYUKUNSA L M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-4-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Mt. Airy, Md.</u>
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>		ADDRESS <u>Sykesville, Md.</u>	
25a. REC'D BY REGISTRAR <u>JAN 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18053

18053

18053

18053

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16974

CERTIFICATE OF DEATH

16971

1. PLACE OF DEATH a. COUNTY <u>CARROLL CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FINKSBURG RT42 06.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO GENERAL HOSPITAL</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>MAY</u> Last <u>FOWLER</u>				4. DATE OF DEATH Month <u>DEC.</u> Day <u>23</u> Year <u>1966</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 23, 1895</u>	9. AGE (In years lost birthday) yrs. <u>71</u>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATOR, CLOTHING FACTORY</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>HAGERSTOWN, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY H. KRETZER</u>				14. MOTHER'S MAIDEN NAME <u>ANNA PITZNOGEL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-18-1918</u>		17. INFORMANT <u>EDWARD J. FROCK</u> Address <u>1208 STAVE. WESTMINSTER, MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ DUE TO _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 20,</u> 19 <u>66</u> , to <u>Dec 23,</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 23,</u> 19 <u>66</u> , and that death occurred at <u>5:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>John S. Harshey</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/23/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>				22d. ADDRESS <u>8 Anchor St. Westminster, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT VALLEY CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>PLEASANT VALLEY CARROLL CO.</u>	
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr. Westminster, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10011

UNITED STATES OF AMERICA

10011

Blank document with faint horizontal lines and two punch holes on the right side.

16975

CERTIFICATE OF DEATH

16972

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural) Sykesville c. LENGTH OF STAY IN 1b OY OM 24D		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 836 Bonifant Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Helvey Last Fowler		4. DATE OF DEATH Month 12 Day 8 Year 66	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-2-1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unemployed	9. AGE (In years last birthday) 76 IF UNDER 1 YEAR: Months 15 Days 2 IF UNDER 24 HRS.: Hours 19 Min. 66
11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Fowler		14. MOTHER'S MAIDEN NAME Mary-- Helvey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 579-26-9574	17. INFORMANT Hospital Records Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Nephrosclerosis, chronic DUE TO (c) Arteriosclerotic cardiovascular disease years			INTERVAL BETWEEN ONSET AND DEATH 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with arteriosclerosis, cerebral			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. 19	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f. (City or town) (County) (State) ---
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11-14 , 19 66 , to 12-8 , 19 66 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12-8 , 19 66 , and that death occurred at 7:30 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Heinz H. Klaatsch		22b. DATE SIGNED 12-8-66	
22c. PHYSICIAN'S NAME (Type) Heinz H. Klaatsch, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF Dec. 9, 1966	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City or Town) (County) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR Carroll Funeral Home Baltimore		25a. REC'D BY REGISTRAR DEC 27 1966	25b. REGISTRAR'S SIGNATURE James J. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please leave carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100375

DEPARTMENT OF JUSTICE

100375

Washington, D.C.

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

Mr. Tolson

20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16976					16973				
1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Pa</i> b. COUNTY <i>York Co</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester, Md</i>			c. LENGTH OF STAY IN 1b <i>12 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Rock, Pa 75-3</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Long View Nursing Home (128 N Main)</i>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Homer</i> Middle <i>L</i> Last <i>Gemill</i>			4. DATE OF DEATH Month <i>Dec</i> Day <i>16</i> Year <i>1966</i>						
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct 6</i>		9. AGE (In years last birthday) <i>81</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>machinist</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Pa</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>James Gemmill</i>				14. MOTHER'S MAIDEN NAME <i>Mary Miller</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>176-01-3202</i>		17. INFORMANT <i>Mr Ray Patino</i>		Address <i>Glen Rock, Pa</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c) <i></i>								INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>4 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <i>12/4</i> , 1966, to <i>12/16</i> , 1966, that (1) (we) last saw the deceased alive on <i>12/16</i> , 1966, and that death occurred at <i>7:34 PM</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>W.H. Ford</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12/16/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>W.H. Ford M.D.</i>				22d. ADDRESS <i>Manchester, Md 21102</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE THEREOF <i>12/19/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fatheren</i>		23d. LOCATION (City, town or county) (State) <i>Glen Rock Pa</i>			
24. FUNERAL DIRECTOR <i>W.H. Ford</i>				ADDRESS <i>Glen Rock, Pa</i>		25a. REC'D BY REGISTRAR <i>DEC 19 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

10018

10018

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16977 CERTIFICATE OF DEATH 16974

1. PLACE OF DEATH a. COUNTY <u>CARROLL - COUNTY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> c. LENGTH OF STAY IN 1b <u>16 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>226 E. MAIN ST.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> <u>06.1</u> d. STREET ADDRESS <u>226 E. MAIN STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY MAUDE ESTELLA GORSUCH</u> First Middle Last		4. DATE OF DEATH <u>DEC. 15</u> 19 <u>66</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 19 1881</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL COUNTY</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>LEWIS C. SMITH</u>	
14. MOTHER'S MAIDEN NAME <u>HENRIETTA COOK</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>X219-12-21001</u>		17. INFORMANT <u>SAN. RAYMOND S. GORSUCH</u> Address <u>RT # 3 WESTMINSTER, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 443 X DUE TO (b) <u>Arterio-Sclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>Several hours</u> <u>yes</u> <u>yes</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>mental deterioration</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Aug 11</u> , 19 <u>63</u> to <u>Dec 15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 14</u> , 19 <u>66</u> , and that death occurred at <u>11:45</u> AM, from the causes and on the date stated above.	
22a. SIGNATURE <u>W. G. FENN SPEICHER</u> M.D.		22b. DATE SIGNED <u>12-16-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. G. FENN SPEICHER</u>		22d. ADDRESS <u>Westminster Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>DEC 18/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BETHESDA CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>GIST. MD.</u>	
24. FUNERAL DIRECTOR <u>James G. Saffell Jr.</u>		25a. REC'D BY REGISTRAR <u>DEC 19 1966</u>	
ADDRESS <u>WESTMINSTER MD</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10034

10034

16978

CERTIFICATE OF DEATH

16975

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Md.	
c. LENGTH OF STAY IN lb 1 Week		d. STREET ADDRESS 152 Carter Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Josephine Gallagher Greenfield		4. DATE OF DEATH Month Dec. Day 9 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1919
9. AGE (In years last birthday) yrs. 47		10. IF UNDER 1 YEAR Months 11 Days 18 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Gallagher		14. MOTHER'S MAIDEN NAME Ethel Wood	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Mr. Dickson Greenfield		Address Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma right breast with metastasis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July , 19 66 , to Dec 7 , 19 66 , that (I) was last saw the deceased alive on 10/21 , 19 66 , and that death occurred at 2:54 P.M. from causes and on the date stated above.			
22a. SIGNATURE Richard J. Dalrymple		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) RICHARD J. DALRYMPLE		22d. ADDRESS 187 E MAIN ST. WESTMINSTER, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-12-66	
23c. NAME OF CEMETERY OR CREMATORY Springhill Cemetery		23d. LOCATION (City or Town) (County) (State) Easton Md.	
24. FUNERAL DIRECTOR Harry W. Haight		25a. REC'D BY REGISTRAR Sykesville, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE DEC 14 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10038

10038

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535
JAN 10 1964
TO DIRECTOR, FBI
FROM SAC, NEW YORK (100-38861)
SUBJECT: [illegible]
RE: [illegible]

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16979

16978

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster MD #3</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 3#</u>				d. STREET ADDRESS <u>Route 3#</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Virginia Grosse</u>				4. DATE OF DEATH Month Day Year <u>December 7 1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 3 1878</u>	
9. AGE (In years lost birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wif</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert Co, Maryland</u>	
13. FATHER'S NAME <u>Samuel Jones</u>				14. MOTHER'S MAIDEN NAME <u>Sally Prott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or nature of service)				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mary D Shaffer Westminster MD #3</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>May 15</u> 19 <u>66</u> to <u>Dec 7</u> 19 <u>66</u> , that (I) (we) lost the deceased alive on <u>December 6</u> 19 <u>66</u> and that death occurred at <u>4</u> A. M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E Bush</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-7-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E Bush MD</u>				22d. ADDRESS <u>12 Hampstead Rd</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/10/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Winchester Cemetery</u>		23d. LOCATION (City, town, or county) <u>Winchester, Carroll Co MD</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne V Knorothy</u> ADDRESS <u>269 Frederick St Hagerstown</u>				25a. REC'D BY REGISTRAR <u>DEC 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>g Charles Judge</u>	

107

10378

CERTIFICATE OF DEATH

10378

[Faint, illegible text, likely bleed-through from the reverse side of the page]

16980

CERTIFICATE OF DEATH

16977

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b Upperco 13.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital		d. STREET ADDRESS Trenton Road	
3. NAME OF DECEASED (Type or print) JOSHUA MITCHELL HALE		4. DATE OF DEATH Month 12 Day 13 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/14/1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 75 yrs.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joshua T. Hale		14. MOTHER'S MAIDEN NAME Laura Alban	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 215-36-8207	
17. INFORMANT Mrs. Elsie Hale		Address Upperco. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4/20.0 DUE TO Congestive Heart Failure (b) Arteriosclerotic Heart Disease DUE TO Arteriosclerotic Heart Disease (c) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 12 , 1966, to Dec 13 , 1966, that (I) (we) lost saw the deceased alive on Dec 13 , 1966, and that death occurred at 8:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE John S. Harshey		22b. DATE SIGNED 12/13/66	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.		22d. ADDRESS 8 Archer St. Westminster, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/16/66	23c. NAME OF CEMETERY OR CREMATORY Forest Baptist Cemetery	23d. LOCATION (City or Town) (County) (State) Balto. Co. Md
24. FUNERAL DIRECTOR Tipton-Eline Funeral Home, Hampstead, Md.		25a. REC'D BY REGISTRAR DATE DEC 15 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10037

CERTIFICATE OF DEATH

10037

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF INTERMENT

NAME OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

John S. Harkness, Jr.
John S. Harkness, Jr.

John S. Harkness, Jr.
John S. Harkness, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16981					16978						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY CARROLL					a. STATE MARYLAND						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FINKSBURG RT#1					b. COUNTY CARROLL						
c. LENGTH OF STAY IN 1b 73 YRS.					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FINKSBURG, RT#1						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SANDYMOUNT ROAD					d. STREET ADDRESS SANDYMOUNT ROAD						
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH						
First Middle Last GRACE ELLEN HARPEL					Month Day Year DEC. 9 1966						
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 29, 1893		9. AGE (In years last birthday) 73 yrs.			
								IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE			10b. KIND OF BUSINESS OR INDUSTRY -			11. BIRTHPLACE (County & State, or foreign country) CARROLL CO. MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN SLOPP					14. MOTHER'S MAIDEN NAME MINERVA TAYLOR						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -					16. SOCIAL SECURITY NO. -					17. INFORMANT Address SAME HOWARD E. HARPEL, ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis - generalized										Years 1	
331X DUE TO											
Conditions, if any, which gave rise to immediate cause (b) Cerebral Vascular Accident - old										Years 1	
(c), stating the underlying cause last, DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 1963 to December 9, 1966 that (I) (we) last saw the deceased alive on December 9, 1966 , and that death occurred at 10:00 AM , from the causes and on the date stated above.											
22a. SIGNATURE Charles E. McWilliams M.D.										22b. DATE SIGNED 12-9-66	
22c. PHYSICIAN'S NAME (Type) CHARLES E. MC WILLIAMS										22d. ADDRESS 11904 Reisterstown Rd Reisterstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE THEREOF 12/12/66	
23c. NAME OF CEMETERY OR CREMATORY CARROLLTON CHURCH CEM. FINKSBURG RT#1 MD										23d. LOCATION (City, town or county) (State) FINKSBURG RT#1 MD	
24. FUNERAL DIRECTOR'S SIGNATURE J. S. Myers, Jr., Westminster, Md.										25a. REC'D BY REGISTRAR DATE DEC 13 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge											

1833

1833

CHRYSLER TO BIRTH

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16982

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16979

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b ?		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Sykesville at Eldersburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital				d. STREET ADDRESS R.D. 2	
3. NAME OF DECEASED (Type or print) First Middle Last William N. Harris		4. DATE OF DEATH Month Day Year December 16, 19 66		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1897-?	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Black Hills South Dakota	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William L. Harris		14. MOTHER'S MAIDEN NAME Annie M. Nelson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1 218-14-8375		17. INFORMANT 8213 17th Ave. Langley Park, Md. Mr. William L. Harris	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 890.0 DUE TO Anoxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carbon monoxide poisoning (c) (Coal Gas)					INTERVAL BETWEEN ONSET AND DEATH Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Lying on bed in house - died with coal gas			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 4:46 12/16 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Sykesville		20g. (County) Carroll		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE W. Glenn Speicher		M.D.		22. DATE SIGNED 12-16-66	
EXAMINER'S NAME (Type) W. Glenn Speicher		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) 135 S. Main St. Westminster, Md.		Address (Street, city, town, or county) 135 S. Main St. Westminster, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/19/1966		23c. NAME OF CEMETERY Wesley Freedom	
23d. LOCATION (City, town or county) Carroll Co., Md.		23e. REC'D BY REGISTRAR DEC 21 1966			
24. FUNERAL DIRECTOR C. M. Waltz Box 241 Sykesville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge			

10010

10010

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Lungs" and "Heart" are faintly visible.]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16983 CERTIFICATE OF DEATH 16984

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Carroll							
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	d. STREET ADDRESS Central Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
	3. NAME OF DECEASED (Type or print) Melvin Wood	First Hartman	Middle H	Last Hartman	4. DATE OF DEATH Dec. 23 1966	Month Dec.	Day 23	Year 1966	
	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1882	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 84	IF UNDER 24 HRS. Days 84	Hours 84	Min. 84
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Trackman	10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Valentine Hartman	14. MOTHER'S MAIDEN NAME Cornelia Bost			
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. 705 09 0197	17. INFORMANT Mrs. Annie Hartman	Address Sykesville, Md	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary disease (c) Generalised arteriosclerosis	INTERVAL BETWEEN ONSET AND DEATH sudden one yr. 10 yrs.			
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, nephrosclerosis.	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
	21. I certify that (I) (this hospital) attended the deceased from Jan 22, 1961 to Dec. 23, 1966 , that (I) (we) last saw the deceased alive on Dec. 9, 1966 , and that death occurred at 9 A M, from the causes and on the date stated above.	22a. SIGNATURE Sani Okutman	22b. DATE SIGNED Dec. 23. 66	22c. PHYSICIAN'S NAME (Type) Sani Okutman	22d. ADDRESS Sykesville Md.	22e. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. 22f. MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
	23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-26-66	23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery	23d. LOCATION (City, town or county) (State) Mt. Airy Md.	24. FUNERAL DIRECTOR Harvey W. Haight	24a. ADDRESS Sykesville, Md.	25a. REC'D BY REGISTRAR DEC 28 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	

13300

13300

Person

Community

Community

Generalized

Hydrocephalus

San Francisco

CERTIFICATE OF DEATH

16981

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 24 dys.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 212 E. University Parkway	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GERALD Middle WASHINGTON Last HILL		4. DATE OF DEATH Month DECEMBER Day 28 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-22-1898
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Hill		14. MOTHER'S MAIDEN NAME Mary E. Deibel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1918-19		16. SOCIAL SECURITY NO. 217-38-3330	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic cardiovascular disease DUE TO (c) Pulmonary emphysema			
INTERVAL BETWEEN ONSET AND DEATH Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-4-66 , 19__, to 12-28-66 , 19__, that (I) (we) last saw the deceased alive on 12-28-66 , 19__, and that death occurred at 1:30 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Octavio A. Ruiz</i>		22b. DATE SIGNED 12-28-66	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE THEREOF 12/31/66	23c. NAME OF CEMETERY OR CREMATORY David Ridge Cemetery	23d. LOCATION (City or Town) (County) (State) Pikesville, Md.
24. FUNERAL DIRECTOR Wm. F. Tidmore & Sons		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE DEC 30 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18221

5828

2. *Chlorophyll a* and *Chlorophyll b* content of the leaves was determined by the method of Arnon and Whistler (1940).

1
2
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
169885 CERTIFICATE OF DEATH 16982									
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>CARROLL</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Finksburg</u>			c. LENGTH OF STAY IN 1b <u>Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Louisville - Finksburg</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Louisville Road</u>					d. STREET ADDRESS <u>Finksburg-Louisville Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EARL</u> First <u>Chester</u> Middle <u>Hutchinson</u> Last					4. DATE OF DEATH <u>Dec.</u> Month <u>30</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 11, 1891</u>		9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumberman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm Hutchinson</u>					14. MOTHER'S MARDEN NAME <u>Alverna Noel</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes give war or dates of service) <u>190-16-3451</u>		17. INFORMANT Address <u>MRS. Ella Hutchinson - Finksburg</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO <u>arteriosclerotic Cardio Vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>disease</u> DUE TO (c) <u>hypertension CVD.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> <u>15 yrs.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>65</u> to <u>12-30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-30</u> , 19 <u>66</u> , and that death occurred at <u>12:30</u> PM, from the causes and on the date stated above.									
22a. SIGNATURE <u>R. V. Houck, Jr.</u>								22b. DATE SIGNED <u>12-30-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. V. Houck, Jr.</u>				22d. ADDRESS <u>Sykesville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-3-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LAKE View Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sykesville, Md.</u>			
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>				ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

16888

16888

1/10/1914
G. V. D.
13/1

66

50

12

12

66

30

15

12

12

66

X

16986

CERTIFICATE OF DEATH

16983

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 11 mos. 7 dys.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine Route #2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital						d. STREET ADDRESS 13.2							
3. NAME OF DECEASED (Type or print) First Middle Last CARROLL OSCAR HYMILLER						4. DATE OF DEATH Month Day Year DECEMBER 28 19 66							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-22-89		9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer	
10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Nathan Hymiller						14. MOTHER'S MAIDEN NAME Elizabeth (Unknown) - Warner							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-32-1796		17. INFORMANT Address Records, Springfield State Hospital									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with senile brain disease, with psychotic reaction.												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1-21-66 , 19 66 , to 12-28-66 , 19 66 , that (I) (we) last saw the deceased alive on 12-28-66 , 19 66 , and that death occurred at 12:35 PM , from causes and on the date stated above.													
22a. SIGNATURE Octavio A. Ruiz						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-28-66					
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.						22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-31-66		23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville Md.							
24. FUNERAL DIRECTOR Harry W. Haight						25a. REC'D BY REGISTRAR DATE JAN 4 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16987					16984				
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			c. LENGTH OF STAY IN ID <u>2 mo., 7 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>30.4</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>					d. STREET ADDRESS <u>1535 Poplar Grove St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SELBY</u> Middle <u>BENJAMIN</u> Last <u>JOHNSON</u>					4. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-1-99</u>		9. AGE (in years last birthday) <u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paint maker</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Johnson</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Brown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>218 07 2596</u>		17. INFORMANT <u>Records, Springfield State Hospital</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute & chronic myocardial infarction (septal)</u> 420.1 DUE TO <u>coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute pulmonary embolism.</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>Minutes and months</u> <u>Years</u> <u>Minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>10-11-66</u> , 19 <u>66</u> to <u>12-11-66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>(2) 11</u> 19 <u>66</u> , and that death occurred at <u>7:30</u> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Huell E. Connor Jr.</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>12-11-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>HUELL E. CONNOR-JR.</u>					22d. ADDRESS <u>Springfield State Hospital, Sykesville,</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/15/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Catharine</u>		23d. LOCATION (City, town or county) _____ (State) _____			
24. FUNERAL DIRECTOR <u>Miss Sarah Hays</u> <u>638 N. E. ... St.</u> <u>Baltimore</u>					25a. REC'D BY REGISTRAR <u>DEC 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16988

CERTIFICATE OF DEATH

16985

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MANCHESTER</u> c. LENGTH OF STAY IN lb <u>3 MO.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>218 S. MAIN ST.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MANCHESTER</u> d. STREET ADDRESS <u>218 S. MAIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DAVID EDWARD KALTRIDER</u> First Middle Last			4. DATE OF DEATH <u>DEC 9 1966</u> Month Day Year				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 22, 1922</u>	9. AGE (In years lost birthday) yrs. <u>43</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TREE TRIMMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FORESTRY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>YORK COUNTY, PA.</u>			
13. FATHER'S NAME <u>JOHN PETER KALTRIDER</u>			14. MOTHER'S MAIDEN NAME <u>BESSIE EDNA MASEMER</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-14-5327</u>		17. INFORMANT Address <u>106 GEORGE ST.</u> <u>WIFE MRS. BETTY B. KALTRIDER WESTMINSTER, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>4 MO</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>7/27</u> , 19 <u>66</u> , to <u>12/9/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/8</u> , 19 <u>66</u> , and that death occurred at <u>6:25 P</u> M, from causes on and on the date stated above.							
22a. SIGNATURE <u>D. A. Knight</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) <u>D. A. Knight M.D.</u>				22d. ADDRESS <u>Shenandoah, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>DEC 13/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CEM.</u>			
23d. LOCATION (City or Town) (County) (State) <u>SILVER RUN, CARROLL, MD</u>							
24. FUNERAL DIRECTOR <u>James E. Saffell Jr.</u>			25a. REC'D BY REGISTRAR ADDRESS: <u>254 E. MAIN STREET</u> <u>WESTMINSTER, MD.</u>				
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			DATE <u>DEC 12 1966</u>				

4431

2201

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

<div> <div>1</div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>16989</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>16986</div> </div> </div>										
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Carroll					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead			c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Gross Mill Rd.					d. STREET ADDRESS Gross Mill Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) James Michael Keefer First Middle Last					4. DATE OF DEATH Dec. 27, 1966 Month Day Year					
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1949		9. AGE (In years last birthday) 17 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Army			10b. KIND OF BUSINESS OR INDUSTRY Active Army		11. BIRTHPLACE (State or foreign country) Balto. City Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Calvin Elmer Keefer					14. MOTHER'S MAIDEN NAME Isabelle Christine Haynes					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 217-50-1853		17. INFORMANT Calvin E. Keefer Hampstead, Md. Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 891.0 Anoxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Carbon monoxide Poisoning DUE TO (b) Carbon monoxide Poisoning DUE TO (c) Carbon monoxide Poisoning								INTERVAL BETWEEN ONSET AND DEATH Short Time		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) apparently fell asleep in car in garage with motor running while working on car							
20c. TIME OF INJURY Month, Day, Year 11:00 a.m. 12/27/66 p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Garage at home		20f. (City or town) (County) (State) Rd Hampstead Carroll Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE W. L. Speicher					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					22. DATE SIGNED 12-28-66					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 12/30/66		23c. NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery		23d. LOCATION (City, town or county) (State) Carroll Co. Md.	
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.					25a. REC'D BY REGISTRAR JAN 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

10386

10386

10386 - 10386

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16990 CERTIFICATE OF DEATH 16987

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>4379 Crest Heights Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FANNIE SHO COHEN KERMISCH</u>		4. DATE OF DEATH Month Day Year <u>DEC 16 1966</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>R Joseph Cohen</u>		14. MOTHER'S MAIDEN NAME <u>Miriam</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212 01 8775-B</u>	
17. INFORMANT <u>Records of Springfield State Hospital,</u>		Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>action</u> <u>Chronic brain syndrome, cerebral arteriosclerosis with psychotic re-</u> INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-13-66</u> , 19 <u>66</u> , to <u>12/16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-16</u> , 19 <u>66</u> , and that death occurred at <u>1:50 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul G. Ensor, M.D.</u>		22b. DATE SIGNED <u>16 Dec 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Paul G. Ensor, M.D.</u>		22d. ADDRESS <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/18/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Windsor Mill Rd</u>		23d. LOCATION (City, town or county) (State) <u>Balto. MD</u>	
24. FUNERAL DIRECTOR <u>Sylvan Lewis & Son's 4600 Liberty</u>		25a. REC'D BY REGISTRAR <u>DEC 19 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
<div style="display: flex; justify-content: space-between;"> 16991 Items 11, 12 Film G304 12/29/66 mh 16988 </div>									
1. PLACE OF DEATH a. COUNTY Carroll					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			d. STREET ADDRESS Route 32	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Grand View Nursing Home					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Mary Middle D. Last Klingelhofer					4. DATE OF DEATH Month December Day 23 Year 1966				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 28, 1882		9. AGE (In years last birthday) 84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never worked			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) USA			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles W. Klingelhofer					14. MOTHER'S MAIDEN NAME Christina				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Grand View Nursing Home Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (b) GENERAL ARTEROSCLEROSIS DUE TO (c) PARTIAL INTESTINAL OBSTRUCTION, ORIGIN UNKNOWN					INTERVAL BETWEEN ONSET AND DEATH 20+yrs. 20+yrs. 2+yrs.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 27/Sept/66 , 19 66 , to 23/Dec/66 , 19 66 , that (I) (we) last saw the deceased alive on 23/Dec/66 , 19 66 , and that death occurred at 8:30 AM on the causes and on the date stated above.									
22a. SIGNATURE <i>H. Lawson</i>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) Mm. H. Lawson, Jr., M. D.					22d. ADDRESS RD #2, Sykesville, Maryland 21784				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/24/1966		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Wm. J. Thibner & Sons					25a. REC'D BY REGISTRAR DEC 27 1966				
					25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>				

10331

10331

Central

Central

Central

Central

Central

Central

Central

Central

Central

Central

Central

Central

Central

Central

Central

Central

Central

Central

Central

Central

Central

Central

Central

Central

Central

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16992 CERTIFICATE OF DEATH 16989											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville, Md.</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finksburg - Maryland.</u>					
c. LENGTH OF STAY IN 1b <u>Typ. 5mo. 8d.</u>						d. STREET ADDRESS <u>Rural</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>											
3. NAME OF DECEASED (Type or print) <u>George Washington Knouse Sr</u>						4. DATE OF DEATH <u>12 9 1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-18-84</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sawm. ll laborer</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Sawmill</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania, Perry Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Knouse (dec.)</u>						14. MOTHER'S MAIDEN NAME <u>Unknown Mann (dec.)</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>218-54480</u>		17. INFORMANT <u>Mrs. Nancy Knouse</u> Address <u>Finksburg - Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene of left foot with toxemia</u> 4501 DUE TO (b) <u>Branchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Days</u> <u>Years</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>7-1-</u> , 19 <u>57</u> , to <u>12-9-</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-9-</u> , 19 <u>66</u> , and that death occurred at <u>8:30</u> PM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Suha Ozgan</u>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>Suha OZGAN</u>						22d. ADDRESS <u>Springfield State Hospital.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/12/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Mem. Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Finksburg Md.</u>					
24. FUNERAL DIRECTOR <u>Tipton-Eline Fun. Home, Hampstead, Md.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
DATE <u>DEC 13 1966</u>											

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16993

16990

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 15 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRINGFIELD STATE HOSP.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - CHAGERTOWN. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First HOMER Middle JEFFERSON Last LACY		4. DATE OF DEATH Month 12 Day 8 Year 1966		5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-15-88		9. AGE (In years last birthday) 78 yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) VIRGINIA				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME DECEASED James Lacy				14. MOTHER'S MAIDEN NAME DECEASED				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 219-20-3135				17. INFORMANT Hosp - Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cardiac-vascular arterio sclerotic dis. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)																INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 11-23 , 19 66 , to 12-8 , 19 66 , that (I) (we) last saw the deceased alive on 12-8 , 19 66 , and that death occurred at 8 P. M, from the causes and on the date stated above.																			
22a. SIGNATURE H. Connor				22b. DATE SIGNED 12-8-66				22c. PHYSICIAN'S NAME (Type) Dr. Huell E. Connor				22d. ADDRESS SPRINGFIELD STATE HOSP.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/12/66				23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				23d. LOCATION (City, town or county) (State) Hagerstown, Washington, Md.							
24. FUNERAL DIRECTOR Rest Haven Funeral Chapel, Inc. Hagerstown, Md.				25a. REC'D BY REGISTRAR Charles Judge				25b. REGISTRAR'S SIGNATURE Charles Judge				DATE DEC 12 1966							

16390

16390

THE STATE OF NEW YORK
IN SENATE
January 15, 1903
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
MAY 1, 1899
ALBANY: J. B. LIPPINCOTT & CO. PRINTERS.
1903.

16994

CERTIFICATE OF DEATH

16994

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>17 HRS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>16 KEMPER AVE.</u>		d. STREET ADDRESS <u>16 Kemper Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>HENRY</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>December</u> Day <u>21</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 17, 1886</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>21</u> Days <u>19</u> Hours <u>66</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RURAL MAIL CARRIER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARROLL CO. MD.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY MARTIN</u>		14. MOTHER'S MAIDEN NAME <u>ELEANOR HOUCK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>213-24-9843A</u>	
17. INFORMANT <u>MRS. JOHN H. MARTIN,</u>		Address <u>SAME ADDRESS</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>334X</u> IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> DUE TO <u>General Arteriosclerosis</u> (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5 mo.</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug.</u> , 19 <u>66</u> , to <u>12-21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-21</u> , 19 <u>66</u> , and that death occurred at <u>6A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Maurice C. Porterfield</u>		22b. DATE SIGNED <u>12-21-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Maurice C. Porterfield</u>		22d. ADDRESS <u>HAMPSTEAD, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/23/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LEISTERS CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>WESTMINSTER RD #4</u>
24. FUNERAL DIRECTOR <u>J. E. Imperio, Jr., Westminster, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge, Md.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18881

RECORD OF DEATH

18881

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Burial Place	
John Doe		45		Male		White		Catholic		Single		Farmer		Heart Disease		Jan 15, 1900		New York		St. Mary's Church	
Name of Informant		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Burial Place	
Jane Doe		40		Female		White		Catholic		Single		Homemaker		Heart Disease		Jan 15, 1900		New York		St. Mary's Church	
Name of Informant		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Burial Place	
John Doe		45		Male		White		Catholic		Single		Farmer		Heart Disease		Jan 15, 1900		New York		St. Mary's Church	
Name of Informant		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Burial Place	
Jane Doe		40		Female		White		Catholic		Single		Homemaker		Heart Disease		Jan 15, 1900		New York		St. Mary's Church	

TO BE FILLED BY THE REGISTRAR OF DEATHS

1. Name of Deceased

2. Age

3. Sex

4. Race

5. Religion

6. Marital Status

7. Occupation

8. Cause of Death

9. Date of Death

10. Place of Death

11. Burial Place

12. Name of Informant

13. Age

14. Sex

15. Race

16. Religion

17. Marital Status

18. Occupation

19. Cause of Death

20. Date of Death

21. Place of Death

22. Burial Place

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16995

16992

I. PLACE OF DEATH e. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middleburg d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Brookfield Manor Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Taneytown d. STREET ADDRESS East Baltimore Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Edward Harison Miller				4. DATE OF DEATH Month Day Year December 19 1966					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 18, 1875		9. AGE (In years last birthday) 91 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Miller				14. MOTHER'S MAIDEN NAME Susan Foreman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Charles R. Miller		Address Taneytown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis cardiovascular disease 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								INTERVAL BETWEEN ONSET AND DEATH 3 days	
20c. TIME OF INJURY Hour e.m. p.m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 6/3/66 12/19/66	
21. I certify that (I) (this hospital) attended the deceased from 12/18/66 , 19 , to 12/19/66 , 19 , that (I) (we) last saw the deceased alive on 12/18/66 , 19 , and that death occurred at 2:40 PM , from the causes and on the date stated above.									
22a. SIGNATURE J. H. Caricofe 22c. PHYSICIAN'S NAME (Type) J. H. Caricofe, M.D.				22b. DATE SIGNED 12/19/66		22d. ADDRESS Union Bridge, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/21/66		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City, town or county) (State) Taneytown Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE John M. Skiles C.O. Fuss & Son, John M. Skiles, Taneytown, Md.						25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge DATE DEC 21 1966			

1893

1893

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

January 11

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
35DD 4-64

FOR STATE
HEALTH DEPT.

1
M

16996

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16998

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 1yr.8mos.14dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3648 Ash Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First GEORGE Middle EDWARD Last MONTGOMERY			4. DATE OF DEATH Month December Day 13 Year 19 66		
5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 1-15-98		
9. AGE (In years last birthday) 68 yrs.			10. IF UNDER 1 YEAR Months 30 Days 4		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William H. Montgomery			14. MOTHER'S MAIDEN NAME Annie E. Fogler		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 215-07-6563		
17. INFORMANT Records, Springfield State Hospital			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to Strangulation by Hanging Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Strangulation by Hanging DUE TO (c) Strangulation by Hanging PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Involuntional psychotic reaction, depressed type.			INTERVAL BETWEEN ONSET AND DEATH 3 1/4 hrs		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was hanging from shower curtain bath room 1386 and his neck		
20c. TIME OF INJURY Month, Day, Year 5:00 a.m. 12/13 1966			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bathroom			20f. (City or town) (County) (State) Springfield State Hospital Sykesville, Carroll, Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE W. Glenn Speicher			22. DATE SIGNED 12/13/66		
EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.			22. DATE SIGNED 12/13/66		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/19/1966		
23c. NAME OF CEMETERY OR CREMATORY Harfieldburg			23d. LOCATION (City, town or county) (State) Westminster Md		
24. FUNERAL DIRECTOR Haight Funeral Home, Sykesville, Md.			25a. REC'D BY REGISTRAR DEC 19 1966		
			25b. REGISTRAR'S SIGNATURE Charles Judge		

10000

10000

Dr. J. C. ...
...

...

...

...

...

...

...

...

...

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16997

CERTIFICATE OF DEATH

16994

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D. 3		d. STREET ADDRESS R. D. 3	
3. NAME OF DECEASED (Type or print) First Albert Middle D. Last Nickoles		4. DATE OF DEATH Month December Day 14 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1893
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR Months 14 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Constructor		10b. KIND OF BUSINESS OR INDUSTRY Carroll Co., Md.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Nickoles		14. MOTHER'S MAIDEN NAME Emma T. Heiser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 113-05-3274	
17. INFORMANT Mrs. Katherine A. Nickoles		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Steroid-induced heart disease DUE TO (b) angina pectoris, coronary DUE TO (c) thrombosis - cardiac arrest		INTERVAL BETWEEN ONSET AND DEATH Nov 1966 12-14-66	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov , 19 66 , to 12-14 , 19 66 , that (I) (we) last saw the deceased alive on 12-14 , 19 66 , and that death occurred at 10:20 PM , from causes and on the date stated above.			
22a. SIGNATURE Howard E. Hall		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) HOWARD E. HALL MD		22d. ADDRESS SYKESVILLE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/17/1966	
23c. NAME OF CEMETERY OR CREMATORY Providence Cemetery		23d. LOCATION (City or Town) (County) (State) Carroll Co., Md.	
24. FUNERAL DIRECTOR C. M. Waltz Box 241 Sykesville, Md.		25a. REC'D BY REGISTRAR DEC 19 1966	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9231

16024

16998

CERTIFICATE OF DEATH

16995

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>---</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SYKESSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE (24)</u>	
c. LENGTH OF STAY IN 1b <u>6 yr. 6 mo. 5 da</u>		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>2927 Hudson St</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>Ochab</u> Last <u>Ochab</u>		4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-29-1879</u>
9. AGE (In years lost birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM KENCZESZKI</u>		14. MOTHER'S MAIDEN NAME <u>JOSEPHINE JAWORSKI</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>RECORDS - Springfield State Hosp</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRCULATORY COLLAPSE</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ATHEROSCLEROSIS</u> DUE TO (c) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>---</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-20</u> , 19 <u>66</u> , to <u>12-25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-25</u> 19 <u>66</u> , and that death occurred at <u>9 P.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>12-25-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>I. E. HAPNER</u>		22d. ADDRESS <u>Springfield State Hospital Sykesville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/29/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Mary</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Co., Maryland</u>
24. FUNERAL DIRECTOR <u>[Signature]</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>DEC 29 1966</u>	

10000

10000

10000

Blank ledger page with horizontal ruling lines and vertical column lines. The page contains faint, illegible text and markings, including the number '10000' in the top left and top right corners. There are two black circular marks on the right edge of the page.

16999

CERTIFICATE OF DEATH

16996

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb six years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 5866 Belair Road	
3. NAME OF DECEASED (Type or print) Clinton James Parks		4. DATE OF DEATH Month 12 Day 24 Year 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-01
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 24 Days 24 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Gas Station	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Asa Parks		14. MOTHER'S MAIDEN NAME Geneva White	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-14-3233	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Head Failure DUE TO (b) Coronary Arteriosclerosis DUE TO (c) Chronic Brain Syndrome as to Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome as to Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Glenn S. Squires		22b. DATE SIGNED 12/24/66.	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/27/66.	
23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DEC 27 1966	
25b. REGISTRAR'S SIGNATURE Philips, Jr.			

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000



1000

MDARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17000

16997

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>	
c. LENGTH OF STAY IN lb <u>2 Days</u>		d. STREET ADDRESS <u>Mineral Hill Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>H.</u> Last <u>Phillips</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>12</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1873</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Frizzell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>2A-20-1719</u>	
17. INFORMANT <u>Mr. Carroll Phillips - Sykesville Md.</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/12</u> , 19 <u>66</u> , to <u>12/14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/14</u> , 19 <u>66</u> , and that death occurred at <u>2:50</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u>		22b. DATE SIGNED <u>12/14/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>8400 St Westminster Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12-17-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Old Oakland Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Sykesville Md.</u>
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>		25a. REC'D BY REGISTRAR <u>Sykesville, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 19 1966</u>	

10001

RECEIVED

10001

RECEIVED
10001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
17001 CERTIFICATE OF DEATH 16998									
1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SYKESVILLE c. LENGTH OF STAY IN ID 41 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2413 FRANCIS ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Elsie Elizabeth Pinckney					4. DATE OF DEATH Month Day Year 12 7 1966				
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-8-94		9. AGE (In years last birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cook		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Eligah Taylor					14. MOTHER'S MAIDEN NAME Mary Pitts				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-30-5590A		17. INFORMANT Address Records - Springfield State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with senile brain disease with psychotic reaction.									INTERVAL BETWEEN ONSET AND DEATH 4200 days years
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-38 , 1966, to 12-7 , 1966, that (I) (we) last saw the deceased alive on 12-7 , 1966, and that death occurred at 11 P.M. , from the causes and on the date stated above.									
22a. SIGNATURE Rita S. Glahn					22b. DATE SIGNED 12/8/66		22c. PHYSICIAN'S NAME (Type) Rita S. Glahn		
22d. ADDRESS Springfield State Hospital, Sykesville Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
23b. DATE THEREOF 12-12-66		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION (City, town or county) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR ADDRESS Charles R. Law 802 Madison Ave., Balto., Md.					25a. REC'D BY REGISTRAR DEC 14 1966				
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

10332

CENTRAL OF DEATH

10332

SPRINGFIELD STATE HOSPITAL
SPRINGFIELD, MASS.
JANUARY 1912
F. L. Taylor
100 N. Main St.
Springfield, Mass.

Psychotic condition.
On this case symptoms associated with senile dementia with
arteriosclerosis heart disease
iron pyrophosphate

SPRINGFIELD STATE HOSPITAL, SPRINGFIELD, MASS.
JANUARY 1912
F. L. Taylor
100 N. Main St.
Springfield, Mass.

17002

CERTIFICATE OF DEATH

16999

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 9mos. 8dys.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS *****	
3. NAME OF DECEASED (Type or print) First CALVIN Middle FRANK Last PRESTON		4. DATE OF DEATH Month DECEMBER Day 12 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-25-30
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John P. Preston		14. MOTHER'S MAIDEN NAME Gladys M. Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-24-5108	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 193.9 IMMEDIATE CAUSE (a) Oligodendroglioma DUE TO (b) Bronchopneumonia DUE TO (c) Infected decubitus ulcers Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Years Days Weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with new growth with behavioral reaction (oligodendroglioma, recurrent, and brain surgery)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-4-66 , 19 to 12-12-66 , 19, that (I) (we) last saw the deceased alive on 12-12-66 , 19, and that death occurred on 12-12-66 at 1:55A M, from causes and on the date stated above.			
22a. SIGNATURE <i>H. E. Connor, Jr.</i>		22b. DATE SIGNED 12-12-66	
22c. PHYSICIAN'S NAME (Type) H. E. Connor, Jr., M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/14/66	
23c. NAME OF CEMETERY OR CREMATORY Good Hope		23d. LOCATION (City or Town) (County) (State) Barton -Allegany, Md.	
24. FUNERAL DIRECTOR <i>E. J. Brou</i>		25a. REC'D BY REGISTRAR DATE DEC 16 1966	
ADDRESS Westernport, Md.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17003

CERTIFICATE OF DEATH

17000

1. PLACE OF DEATH a. COUNTY <u>CARROLL CO.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> c. LENGTH OF STAY IN lb <u>6 WEEKS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>06.1 WESTMINSTER</u> d. STREET ADDRESS <u>108 S. MAIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BETTY</u> <u>ROGOWITZ</u> First Middle Last			4. DATE OF DEATH <u>12</u> <u>23</u> <u>1966</u> Month Day Year				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 8, 1902</u>	9. AGE (In years last birthday) <u>64</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATOR CLOTHING FACTORY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Knollville, Tenn.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>			
13. FATHER'S NAME <u>STEPHEN W. RENO</u>			14. MOTHER'S MAIDEN NAME <u>INEZ MARIA MOORE</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>	17. INFORMANT <u>MRS WM. S. COONEY, JR.</u> Address <u>195 E. MAIN ST. WESTMINSTER, MD.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>WEGENER'S GRANULOMATOSIS</u> <u>231X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>6 MO.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>12/19</u>, 19<u>66</u>, to <u>12/23</u>, 1966, that (I) (we) last saw the deceased alive on <u>12/23</u>, 1966, and that death occurred at <u>6:28</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Vincent J. Fiocco, Jr.</u>			22b. DATE SIGNED <u>12/23/66</u>		22c. PHYSICIAN'S NAME (Type) <u>VINCENT J. FIOCCO, JR.</u>		
22d. ADDRESS			22e. REC'D. BY REGISTRAR <u>DEC 27 1966</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE THEREOF <u>12/27/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BETH DAVID CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>LONG ISLAND NEW YORK</u>		
24. FUNERAL DIRECTOR <u>J. E. Smyer, Jr., Westminster, Md.</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9051

6052

WESTERN UNIVERSITY

12/21

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
17004					CERTIFICATE OF DEATH					17001				
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN lb 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					d. STREET ADDRESS 2010 Maryland Ave.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First HARVARD Middle WALLACE Last RONEY					4. DATE OF DEATH Month DECEMBER Day 5 Year 19 66									
5. SEX Male		6. COLOR OR RACE /White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7-14-02		9. AGE (In years last birthday) yrs. 64		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Edward Roney					14. MOTHER'S MAIDEN NAME Mary Deary									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk.			16. SOCIAL SECURITY NO. 153-01-0843		17. INFORMANT Records, Springfield State Hospital					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced, bilateral cavitory pulmonary tuberculosis DUE TO (b) tuberculosis DUE TO (c) tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH Years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Alcoholism (addiction)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 11-29-66 , 19 to 12-5-66 , 19, that (I) (we) last saw the deceased alive on 12-5-66 , 19, and that death occurred at 11:30 PM , from causes and on the date stated above.														
22a. SIGNATURE <i>Julian Radzykewicz, M.D.</i>					22b. DATE SIGNED 12-6-66									
22c. PHYSICIAN'S NAME (Type) Julian Radzykewicz, M.D.					22d. ADDRESS Springfield State Hospital Sykesville, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-12-66		23c. NAME OF CEMETERY OR CREMATORY Freedom Cemetery			23d. LOCATION (City or Town) (County) (State) Sykesville Md.							
24. FUNERAL DIRECTOR Harry W. Haight					25a. REC'D BY REGISTRAR Sykesville, Md.					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

13001

TECHNICAL DEPT

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

TE DEC 21 1961

17008

DEPARTMENT OF HEALTH

17008

Name		Age		Sex		Race		Religion		Marital Status		Occupation		Education		Income		Assets		Liabilities		Insurance		Other	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17006

CERTIFICATE OF DEATH

17003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These plates remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN lb <u>1 DAY</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		d. STREET ADDRESS <u>532 OLD BALTIMORE RD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUISE CLARA RUMBOLD</u>		4. DATE OF DEATH Month Day Year <u>12 1 19 66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 19, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9. AGE (In years last birthday) <u>75</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ANTON ERMER</u>		14. MOTHER'S MAIDEN NAME <u>ANNA (UNKNOWN)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-28-5327</u>	
17. INFORMANT <u>ALBERT RUMBOLD</u>		Address <u>NEW WINDSOR MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>YEARS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>PNEUMONITIS, BILATERAL</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/30</u> , 19 <u>66</u> , to <u>12/1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/1</u> , 19 <u>66</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Vincent J Fiocco Jr</u>		22b. DATE SIGNED <u>12/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>VINCENT J FIOCCO JR</u>		22d. ADDRESS <u>WESTMINSTER MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12/3/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER</u>	23d. LOCATION (City or Town) (County) (State) <u>WESTMINSTER MD</u>
24. FUNERAL DIRECTOR <u>W S Hartzler & Sons New Windsor MD</u>		25a. REC'D BY REGISTRAR <u>DEC 5 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
17007		CERTIFICATE OF DEATH	
17004			
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural--Sykesville</u>		c. LENGTH OF STAY IN lb <u>5mo. 5days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>2600 Ailsa Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Catherine</u> Last <u>Russell</u>		4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>19 66</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/20/83</u>
9. AGE (In years last birthday) yrs. <u>83</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Duffy</u>		14. MOTHER'S MAIDEN NAME <u>Ella Duffy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-16-2223</u>	
17. INFORMANT <u>Springfield Hospital records, Sykesville, Md.</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>309X</u> IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic brain syndrome associated with senile brain disease with psychotic reaction.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>it</u> (this hospital) attended the deceased from <u>7/15/</u> , 19 <u>66</u> , to <u>12/20/</u> , 19 <u>66</u> , that <u>it</u> (we) last saw the deceased alive on <u>12/20/</u> 19 <u>66</u> , and that death occurred at <u>9:00a</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>12/20/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Naci N. Buyukunsal, M.D.</u>		22d. ADDRESS <u>Springfield State Hospital</u> <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/23/66.</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 21 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

13001

13001

OFFICE OF THE

COMMUNITY

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

13001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17008											
17005											
1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ROUTE #3 BOX 222 WESTMINSTER c. LENGTH OF STAY IN 1b 24 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WESTMINSTER, MD					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ROUTE #3 WESTMINSTER d. STREET ADDRESS BOX 222 061 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) ALVERTA VIRGINIA SELLERS First Middle Last					4. DATE OF DEATH DEC 16 1966 Month Day Year						
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG 31 1972 yrs. Months Days Min.		9. AGE (In years last birthday) 94 IF UNDER 1 YEAR IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME David Ruby					14. MOTHER'S MAIDEN NAME Mary Jane Henry						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 213-50-5954		17. INFORMANT CORA E BASSLER ROUTE #3 WESTMINSTER MD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) 9 YEARS								INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from DEC 16 1966 , to DEC 16 1966 , that (I) (we) last saw the deceased alive on DEC 16 1966 , and that death occurred at 7:50 M, from the causes and on the date stated above.											
22a. SIGNATURE Daniel I Welliver 22c. PHYSICIAN'S NAME (Type) DANIEL I WELLIVER					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-16-66				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 12/19/66		23c. NAME OF CEMETERY OR CREMATORY Leister's Cemetery				
23d. LOCATION (City, town or county) Carroll Co.					23e. (State) Md.						
24. FUNERAL DIRECTOR Tipton-Eline Funeral Home, Hampstead, Md.					25a. REC'D BY REGISTRAR DEC 20 1966					25b. REGISTRAR'S SIGNATURE Charles Judge	

1000

1000

1000

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17009

CERTIFICATE OF DEATH

17006

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middleburg</u> c. LENGTH OF STAY in 1b <u>6 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brookfield Manor Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural--Westminster</u> d. STREET ADDRESS <u>R.D. # 6</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>C.</u> Middle <u>URNER</u> Last <u>SHIPLEY</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>5.</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Grove J. Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Annie Zepp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Ralph G. Hoffman,</u> Address <u>Westminster, Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerotic cardiovascular disease</u> (b) <u>Pneumonia</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/19/66</u> , 19 <u>66</u> , to <u>12/5/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/4/66</u> , 19 <u>66</u> , and that death occurred at <u>7:20</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>J. H. Caricofe</u>		22b. DATE SIGNED <u>12/5/66</u>	22c. PHYSICIAN'S NAME (Type) <u>J. H. CARICOFE</u>
22d. ADDRESS <u>Union Bridge, Md.</u>		22e. REC'D BY REGISTRAR <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-7-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Deer Park</u>
23d. LOCATION (City, town or county) <u>Carroll Co. Maryland</u>		23e. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C.M. Waltz, Box 241, Sykesville, Md.</u>		24b. ADDRESS	

17008

CERTIFICATE OF DEATH

17008

17008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17070 CERTIFICATE OF DEATH 17007											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Md</u>				c. LENGTH OF STAY IN 1b <u>16 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md.</u> <u>06/1</u>				d. STREET ADDRESS <u>4 N. Main St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Long View Nursing Home 130 N. Main</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Cecilia M.</u>			First Middle Last			4. DATE OF DEATH <u>Dec 15 1966</u>			Month Day Year		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 25 - 1865</u>		9. AGE (In years last birthday) <u>101</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George A Shower</u>						14. MOTHER'S MAIDEN NAME <u>MARY E McIlhenny</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>220-44-8513</u>		17. INFORMANT <u>George Shower</u>			Address <u>Lanerytown, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gastro intestinal hemorrhage</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiac</u> DUE TO (c) <u>vascular disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>47</u> , to <u>Dec 15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 15</u> , 19 <u>66</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>W H Foard</u>						22b. DATE SIGNED <u>12/15/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>W. H Foard M.D.</u>						22d. ADDRESS <u>Manchester, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/18/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Manchester Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Manchester Md.</u>					
24. FUNERAL DIRECTOR <u>Tipton-Eline Fun. Home, Hampstead, Md.</u>						25a. REC'D BY REGISTRAR <u>DEC 20 1966</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

13003

13010



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

17011

17008

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead RFD</u>		c. LENGTH OF STAY IN lb <u>24 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead RFD</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Helen</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2-1902</u>
9. AGE (In years last birthday) <u>64 yrs.</u>		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Fred Rier</u>		14. MOTHER'S MAIDEN NAME <u>Louise Schulties</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-20-8912</u>	
17. INFORMANT <u>Mr Lewis Smith Sr</u>		Address <u>Hampstead, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>widespread metastases</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>if Rec</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>51</u> , to <u>Dec 9</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>Dec 5</u> , 19 <u>66</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Foard</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>25 N. Main St 12/9/66</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>		<u>Manchester, Md 21102</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/12/66</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sater's Baptist Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton-Eline Fun. Home, Hampstead, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 13 1966</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

17012

CERTIFICATE OF DEATH

17009

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville c. LENGTH OF STAY IN lb 7 yr 2 mons d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland 21206 d. STREET ADDRESS 5740 Cedonia Ave. 4600 Rapse Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth Genevieve Snyder		4. DATE OF DEATH Month 12 Day 11 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Personal work Waitress-Hasslingers		10b. KIND OF BUSINESS OR INDUSTRY Waitress-Hasslingers	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Michael Barrett	
14. MOTHER'S MAIDEN NAME Mary Coulehan		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 12-01-40924		17. INFORMANT Springfield Hospital Records, Sykesville	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO (b) Pneumococcal infection DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 9-14 , 19 59 , to 12-11 , 19 66 that (X) (we) last saw the deceased alive on 19 , and that death occurred at 7:20 AM , from causes and on the date stated above.			
22a. SIGNATURE Mario E. Comas M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) MARIO E. COMAS		22d. ADDRESS 1302 KENSEL CT.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/14/66	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. REC'D BY REGISTRAR DATE DEC 13 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1995

1971

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17013

CERTIFICATE OF DEATH

17010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN lb <u>hrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural--Sykesville</u>		06/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. General Hospital</u>		d. STREET ADDRESS <u>Liberty Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHERINE H. STEM</u>		4. DATE OF DEATH Month Day Year <u>Dec. 3, 1966</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9, 1916</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec'y, Real Estate & Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>G. Millard Holter</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Kefauver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, aa, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-18-9472</u>	
17. INFORMANT <u>W.F. Stem</u>		Address <u>same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Aneurysm</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 3, 1966</u> , to <u>Dec 3, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec 3, 1966</u> , and that death occurred at <u>6:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u>		22b. DATE SIGNED <u>12/4/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>8 Anchor St. Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12-6-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>	23d. LOCATION (City or Town) (County) (State) <u>Carroll Co., Maryland</u>
24. FUNERAL DIRECTOR <u>C.M. Waltz, Box 241, Sykesville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 7 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

01011

STATE OF TEXAS

17013

Johnston County

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. CDUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. LENGTH OF STAY IN 1b <u>15 YEARS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Liberty Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELLEN</u> Last <u>SULLIVAN</u>		4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 9, 1879</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Richard Fugett</u>		14. MOTHER'S MAIDEN NAME <u>Ann Tett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Mrs Gurney Leatherwood - Sykesville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest, A. S. H. D., pneumonia</u> 4200 DUE TO (b) <u>Chronic brain syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1864</u> <u>28 Dec 66</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>66</u> , to <u>Dec.</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>28 Dec</u> 19 <u>66</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard E. Hall</u>		22b. DATE SIGNED <u>30 Dec 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall</u>		22d. ADDRESS <u>Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>		25a. REPORT BY REGISTRAR DATE <u>JAN 4 1967</u>	
ADDRESS <u>Sykesville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11081

11081

[Faint, illegible text, likely bleed-through from the reverse side of the page]

17015

CERTIFICATE OF DEATH

17012

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster	
c. LENGTH OF STAY IN lb Newborn		d. STREET ADDRESS 820 Baltimore Blvd	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy		4. DATE OF DEATH Month December Day 9 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 9, 1966
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not applicable		10b. KIND OF BUSINESS OR INDUSTRY Not applicable	9. AGE (In years last birthday) yrs. 1 Min. 20
11. BIRTHPLACE (County & State, or foreign country) Carroll County, MD		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME James W. Turfle		14. MOTHER'S MAIDEN NAME Nannie M. Hill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mother - Westminster, Maryland		Address 820 Baltimore Blvd, 21157	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO (b) pulmonary immaturity DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 hr 20 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Absent kidneys and ureters, hypoplastic kidneys, bladder, microcephaly			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 12/9 , 19 66 , to 12/9 , 19 66 , that (1) (we) last saw the deceased alive on 12/9 , 19 66 , and that death occurred at 6:04 AM , from causes and on the date stated above.			
22a. SIGNATURE William R. O'Rourke		22b. DATE SIGNED 12/9/66	
22c. PHYSICIAN'S NAME (Type) William R. O'Rourke, M.D.		22d. ADDRESS 150 W. Main St., Westminster, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Released to hospital	23b. DATE THEREOF Dec. 9 1966	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Carroll Co. Gen. Westminster, Md.		25a. REC'D BY REGISTRAR DEC 19 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12012

12012

Carroll

Carroll

Carroll

Westminster

Westminster

Westminster

Carroll County General Hospital

Carroll County General Hospital

Carroll County General Hospital

December 9, 1966

December 9, 1966

December 9, 1966

December 9, 1966

December 9, 1966

Carroll County General Hospital

Carroll County General Hospital

Carroll County General Hospital

Carroll County General Hospital

Carroll County General Hospital

Carroll County General Hospital

Carroll County General Hospital

Carroll County General Hospital

Respiratory failure

X

12/9/66

12/9/66

12/9/66

12/9/66

12/9/66

12/9/66

12/9/66

12/9/66

12/9/66

12/9/66

Released to Dec. 9, 1966

17016

CERTIFICATE OF DEATH

17013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Sykesville c. LENGTH OF STAY IN lb 4y 2m 1d d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 1507 Frederick Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNA MAE TWIGG		4. DATE OF DEATH Month 12 Day 12 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-93
9. AGE (In years last birthday) 73 1/2 yrs.		10. IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min.	11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Norris		14. MOTHER'S MAIDEN NAME Mary Connors	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-54-6027	
17. INFORMANT Springfield Records, Sykesville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure (days) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic heart disease (years) DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. with cerebral arteriosclerosis with behavioral reaction		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-11 , 19 62 , to 12-12 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12-12 , 19 66 , and that death occurred at 11:00 p.m. from causes and on the date stated above.			
22a. SIGNATURE <i>Ilse Kamm</i>		22b. DATE SIGNED 12-13-66	
22c. PHYSICIAN'S NAME (Type) Ilse Kamm, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 16, 1966	
23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE DEC 16 1966	
25b. REGISTRAR'S SIGNATURE <i>John A. Judge</i>			

17018

17018

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Sex	
Age		Date of Death		Place of Death	
Cause of Death		Occupation		Residence	
Signature of Physician		Signature of Registrar		Signature of Informant	
Date of Issuance		Place of Issuance		County	
State		City		Zip	

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
BUREAU OF VITAL STATISTICS

17017

CERTIFICATE OF DEATH

17014

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 1yr. 6mos. 10dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 8616 Irvington Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LEWIS CALWELL WEST		4. DATE OF DEATH Month Day Year December 1 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-20-75
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis West		14. MOTHER'S MAIDEN NAME Belle Fauntleroy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-6265	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c) Arteriosclerotic heart disease years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-21-65 , 19__, to 12-1-66 , 19__, that (I) (we) last saw the deceased alive on 12-1-66 , 19__, and that death occurred at 1:20 P.M. from causes on and on the date stated above.			
22a. SIGNATURE Octavio A. Ruiz		22b. DATE SIGNED 12-1-66	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-3-66	
23c. NAME OF CEMETERY OR CREMATORY Washington Masonic Cemetery		23d. LOCATION (City or Town) (County) (State) Washington VA.	
24. FUNERAL DIRECTOR Harry W. Haight		25a. REC'D BY REGISTRAR DEC 6 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1973

1503

17018

CERTIFICATE OF DEATH

17015

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN lb 16 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital		d. STREET ADDRESS 6514 Banbury Road	
3. NAME OF DECEASED (Type or print) Charles Steuart White, Jr.		4. DATE OF DEATH Month December Day 20 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 14, 1908
9. AGE (In years last birthday) yrs. 58		IF UNDER 1 YEAR Months 0 Days 3 IF UNDER 24 HRS. Hours 2 Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Dealer		10b. KIND OF BUSINESS OR INDUSTRY Own Agency	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles S. White, Sr.		14. MOTHER'S MAIDEN NAME Blanche Macey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Thrombosis (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 4 , 1966, to Dec 20 , 1966, that (I) (we) last saw the deceased alive on Dec 20 , 1966, and that death occurred at 2:48 P.M., from causes and on the date stated above.			
22a. SIGNATURE John S. Harshey		22b. DATE SIGNED 12/20/66	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.		22d. ADDRESS 8 Anchor St. Westminster, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 23, 1966	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	23d. LOCATION (City or Town) (County) (State) Parkville, Maryland
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		25a. REC'D BY REGISTRAR DEC 27 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~red~~ give carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

65053

6-1051

17019

CERTIFICATE OF DEATH

17016

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE			c. LENGTH OF STAY IN 1b YEARS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE			d. STREET ADDRESS MAIN STREET
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MAIN STREET - RESIDENCE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RUTH JEANNETTE WILSON				4. DATE OF DEATH Month DECEMBER Day 25 Year 1966			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 27, 1894		9. AGE (In years last birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) CARROLL - MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM ECKARD				14. MOTHER'S MAIDEN NAME JEANNETTE MARTIN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MONROE B. WILSON		Address UNION BRIDGE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Atherosclerotic Heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 5/3/66 , 19____, to 12/25/66 , 19____, that (I) (we) last saw the deceased alive on 12/6/66 , 19____, and that death occurred at 11:30 P.M., from causes and on the date stated above.							
22a. SIGNATURE J. H. CARICOFÉ				22b. DATE SIGNED 12/27/66		22c. PHYSICIAN'S NAME (Type) J. H. CARICOFÉ	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 28, 1966		23c. NAME OF CEMETERY OR CREMATORY LINGANORE CEMETERY		23d. LOCATION (City or Town) _____ (County) _____ (State) _____ UNIONVILLE FREDERICK MD.	
24. FUNERAL DIRECTOR D. D. Zarklew Sons				25a. REC'D BY REGISTRAR DEC 29 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

13016

CERTIFICATE OF DEATH

17013

Form with multiple sections and fields, including a large central area with a grid pattern and various text boxes. The form is oriented horizontally and contains several lines of text and a large rectangular area with a grid pattern.

Vertical text on the right side of the page, possibly a date or reference number.